

21st MDG HEALTH MAINTENANCE EVALUATION: PETERSON CLINIC

12-17 Years

Patient	Date	Time	Time arrived	Age	Provider
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Welcome to the Peterson AFB Clinic. We are transitioning to a new electronic medical records system that will allow us to provide your child better health care (notes will be legible, your child's medical record won't be "lost", etc.) Please bear with us while we proceed with this transition.

The electronic medical record system allows us to be very thorough, but it requires a bit more work on the part of the parents. These forms are available on our clinic's webpage if you'd like to complete them before future visits. Eventually we will have electronic records only without any paper charts. This cutting-edge system is Dept of Defense wide, so you may already have experience with this at other clinics. If you feel we could be gathering your medical information in a better way, please feel free to let us know.

****Parents, please answer all questions below and on the reverse page****

Is this your first visit to our clinic?

Who brought the patient today? (mom, dad, guardian, etc.)

Who cares for your child after school? (home, extended family, etc)

Is your child currently taking any medications?

☐ Vitamins ☐ Other

Has your child had any recent hospitalizations, surgeries or new medical diagnosis?

Allergies to medicines, latex, foods or anything else?

What happened exactly with this allergic reaction?

Is there a family history of any of the following diseases? (Please list which family members affected)

- ☐ High cholesterol ☐ High blood pressure
☐ Early sudden death ☐ Heart disease
☐ Genetic cancers ☐ Alcoholism
☐ Drug abuse ☐ Asthma
☐ Suicide ☐ Diabetes
☐ Other _____

Is this visit related to a deployment?

HISTORY/ DEVELOPMENT *(Check all that apply to your child)*

☐ Does your child get regular exercise outside of school?

☐ Does your child watch more than 2 hours of television a day?

☐ Does your child have a television in their room?

☐ Fracture
☐ Seizure
☐ Concussion
☐ Asthma

☐ Poor appetite?
☐ Relationship problems with peers?
☐ Poor school performance?

Any other concerns to discuss?

Review of Systems ° ° ° ° °		Yes (please specify)	No
Fever ? Please circle how you checked it:	Highest Temperature:		
Cough?			
Runny nose?			
Ear pain?			
Rash?			
Diarrhea?			
Hard stools?			
Vomiting or stomach ache?			
Wheezing?			
Joint pains?			
Pain with urination?			
Does anyone smoke in or around your child's home, daycare or car?			
Fainting or loss of conscious?			
Functional Assessment (needs to be completed at <u>first</u> visit to clinic and then annually)		Yes (please specify)	No
Does your child receive any routine therapies (speech therapy, occupational therapy, physical therapy)			
Does your child have any speech, language or communication problems?			
Has your child gained or lost 10 pounds over 3 months without changes in diet?			
Does your child have difficulty with swallowing or frequent choking?			
Does your child have any hearing loss or communication problems?			
Does your child have any loss of vision, double vision, lazy eye or other visual/ eye problems?			
Is your child in a verbally, physically or sexually abusive situation?			
Is your child in danger at home or school?			
If applicable for your child's age, does your child have religious or cultural practices that we should be aware of?			
If applicable for your child's age, does your child have barriers that prevent them from learning?			
What is your family's primary language?			